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The Psychosocial Profile: A History-Taking Aid

SUMMARY

Family physicians need a good history-taking model. All diagnostic possibilities, both physiological and psychological, have to be considered during the history-taking process, with a reliable system of hypothesis formation and testing. A psychosocial profile incorporated into the history correlates symptoms of anxiety and situational depression with significant concerns in the patient's life. This temporal correlation helps to differentiate functional symptoms from organic pathology. (Can Fam Physician 1985; 31:864-868)

SOMMAIRE

Les médecins de famille ont besoin d'un bon modèle de référence pour l'histoire de cas. Toutes les possibilités diagnostiques, tant physiologiques que psychologiques, doivent être considérées au cours du questionnaire, incluant un système efficace de génération et de validation d'hypothèses. L'addition du profil psychologique établit une corrélation entre les symptômes d'anxiété et de dépression situationnelle et les préoccupations significatives dans la vie du patient. Cette corrélation temporelle contribue à différencier les symptômes fonctionnels d'une pathologie organique.

Key words: history, psychosocial profile, stress

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STUDIES SHOW that as many as 50-75% of patients utilizing primary care clinics have psychosocial precipitants as opposed to biomedical problems as the main cause of their visit.[1] This indicates that a biopsychosocial approach, rather than the biomedical model, is needed in a family practice setting.[1,2] The classical systems approach is based on the principle of ruling out organicity. This is a costly and indirect approach to understanding patients' symptoms.[3]

If instead, doctors considered the possibility of a stress condition equally with physical and emotional illness from the outset, the guidelines for assessing symptoms would change. The diagnostic hypotheses would not be ones of exclusion, but those which could be directly supported from the information in the history.

Consider the following vignette:

Patient Profile 1

A 64-year-old man came to the office stating that it had been the worst year of his life. He carried with him a sheet of test results ordered by another doctor for investigation of a nine-month history of a sensation of a lump in his throat. The tests included: ECG, cardiac stress test, endoscopy of esophagus and stomach, thyroid scan, X-rays of chest, right shoulder, neck and hands, upper gastrointestinal series, gallbladder series, barium enema, and multiple blood tests. The results had all been negative. The cost to the medical services plan was approximately $1,000. He was now seeking another opinion.

When questioned about psychosocial factors, he stated that he slept well but had noticed a drop in his mood, increased irritability and increased fatigue for about a year. In the previous four months, he had less interest in food, and a corresponding loss in weight. His sex drive was "OK".

Enquiry into his life's concerns revealed that he had only one. At 64 he was nearing retirement and working at a job he only marginally enjoyed. He felt life was passing him by, and that he was running out of time to fulfill his dreams. His increased concern about his job situation and the onset of his troublesome symptoms had coincided.

The diagnosis, of course, was globus hystericus (a somatic manifestation of anxiety) in conjunction with symptoms of reactive depression.[4]

This patient's history underscores some problems familiar to all family doctors. By using the accepted approach of ruling out organicity, the doctor missed making the diagnosis and then disregarded the rest of the enquiry. This process not only fails to

produce a meaningful diagnosis and treatment plan, but also reinforces somatization. Excessive medical costs were incurred through a management approach which consisted of testing and referrals. In fact, the management of the problem could have begun when the history was taken.

Sandler, a British cardiologist, measured the usefulness of the three basic aspects of clinical assessment—history, physical examination and investigation. He concluded that the history decided the diagnosis in more than two thirds of the cases (630). Clinical examination contributed less than 25% to the diagnosis and routine testing very little (1-9.5%). He recommends that diagnostic conclusions be drawn from the history before embarking on examination.[3]

Barbour studied 400 patients referred to his internal medicine clinic, and found that doctors have an extraordinary preference for using organic illness to explain symptoms. As a result, many diagnoses are wrong. He challenges family doctors to know the probable reality of whether the syndrome has a psychosocial or organic basis and to govern their approach accordingly.[5]

Rosen, Kleinman and Katon meet this challenge, in part, with a biopsychosocial model.[1] When somatization is suspected, (i.e., frequent office visits with ill-defined functional complaints and complex descriptions of symptoms) they recommend a thorough evaluation of these areas: psychological, family, sociocultural, and the nature of the stressors. From this, they derive a diagnosis which consists of

1. Disease
2. Clinical subtype of somatization (acute, subacute, chronic)
3. Nature of the stressors
4. An assessment of social support.

But this otherwise very helpful article does not outline a strategy for establishing a hypothesis that facilitates an understanding of both organic and non-organic symptoms. Basically, doctors need to establish a tentative diagnosis of functional[4] or organic disorder, *or both*, immediately following the history and with more certainty after the physical exam. To be able to do this, the history needs to elicit biopsychosocial information and concurrently initiate a system of hypothesis formation and testing of both organic and functional symptoms. This is no small feat for the family doctor with patients booked 20 minutes apart.

There have been several very good attempts to develop systematic and not unduly time-consuming methods of obtaining information about patients' life problems, emotional status and personal functioning, e.g., Ireton's Personal Inventory,[6] or Holmes and Rahe's Social Readjustment Rating Scale.[7] But even these questionnaires cannot integrate all of the patient's concerns with all of his fully characterized symptoms. Only a history format which deals systematically with physical and psychosocial symptoms *and their correlations* can provide the complete information necessary for diagnosis. The approach outlined in Table 1 uses a psychosocial profile to address this need.

The Approach

This method is especially helpful if the presenting complaint offers diagnostic difficulty or is potentially functional in nature.

Symptom Assessment

To assess for the biological concomitants of depression, inquire about changes in sleep, appetite, weight,

TABLE 1
Psychosocial Profile

Symptom Assessment

1. Presenting complaint.
2. Disturbance(s) in sleep, appetite, weight, mood, sex drive. Increase in irritability, fatigue.
3. Systems enquiry indicators— ? positive for anxiety-related symptoms.
4. Symptom complex formation based on temporal correlation of 1, 2, 3.
5. Characterization of symptoms —aggravating and relieving factors —earmarks of organic disease

Concern Assessment

Areas 1. Job 2. Family 3. Friends 4. Finances 5. Living situation 6. Love life 7. Physical health 8. Any other concern.

Temporal correlation of symptom and concern assessments.

Is an x-y pattern(s) present?

Hypothesis Formation and Testing

1. Tentative diagnosis
2. Physical exam
3. Therapeutic plan and testing.
4. Confirmation or reassessment.

mood, level of irritability, level of fatigue, and sex drive. Note any changes and their durations. This forms a symptom-complex if the time periods coincide. Check if the presenting complaint occurs in the same time period as the alterations in this symptom-complex. If so, this indicates that the presenting complaint may be part of the complex. This is supported if the enquiry into all other systems was negative.

However, the systems enquiry may not have been negative, but may have revealed other complaints commonly related to stress, also occurring in the same time period. These somatic manifestations of anxiety are not asked about specifically but will often surface. They include autonomic and visceral symptoms such as palpitations, lightheadedness, tachycardia, elevated blood pressure, vasomotor changes, tingling of extremities, air hunger, diaphoresis, dry mouth, syncopal episodes, urinary symptoms, nonspecific muscle weakness and nonspecific pain of the abdomen and chest, among others. Intellectual disturbances could include difficulty concentrating, slowed thoughts, poor memory, etc.[8]

The presenting complaint and these additional symptoms must be characterized fully for any general or specific indication of organic disease. For example, organically-induced pain generally persists in a specific area which the patient can easily identify, whereas psychogenic pain is migratory, rarely awakening the patient from sleep.[9] Specific patterns of symptoms will of course indicate organic disease (e.g. duodenal ulcer). Inquire how rest and tension (and other aggravating and relieving factors) affect the presenting complaint.

Concern Assessment

Identify possible areas of dissatisfaction in the patient's life, noting their time of onset. These areas are either problem free or not, and will be explored further at a later time. Areas include: job, family, friends, finances, living situation, love-life, concern over physical health, any other concern. Note whether more than one symptom-concern-complex is emerging, i.e. insomnia, loss of appetite of four months coinciding with marital conflict of four months *and* depressed mood, irritability, nonspecific generalized abdominal discomfort of one month coinciding with concern about job security of one month.

Hypothesis Formation and Testing

The hypothesis (or tentative diagnosis) of a functional complaint secondary to personal concern is made if:
—there is significant dissatisfaction corresponding in time with the onset of the symptom or symptom complex.
—rest helped alleviate the symptoms and tension aggravated them.
—the symptom(s) lacked the earmarks of organic disease.

If the symptoms do not correlate with the onset of the significant concerns in the patient's life, or if the psychosocial profile is in no way altered, then we have some indication of organic disease.

In either case, a physical exam tailored to the situation is indicated to support the tentative diagnosis and for the therapeutic value as well. Observation of the patient's appearance and mood is also an integral part of this process.

Plans for testing the hypothesis are then made. For example, if it is tentatively functional, problem solving or situational therapy might be organized. If it is tentatively organic, lab testing or X-rays might be ordered. Some situations will always require both, e.g. peptic ulcer.

A follow-up appointment is made to confirm whether the hypothesis proved sound.

Discussion

The textbook *Stress and Human Health*,[10] outlines a framework which divides the stress response into these elements: stressors (x), reactions (y), consequences (z) and mediators. Reactions can be biological, psychological or social responses to the stressor. Consequences are physical, psychological or sociological results of such reactions and can be good or bad. Mediators, the filters and modifiers that produce individual variation in the x-y-z sequence, help to explain why some people adapt more easily to stress than others do.

When applying this framework to the approach under discussion, symptoms that are potentially functional (y) are compared temporally with stressors (x) to support the idea that they are, in fact, reactions. The correlation of x and y should fit easily—nothing should be forced. All symptoms are

characterized fully to screen for biological content.

Although distinctions between reactions (more transient responses) and consequences (more prolonged or cumulative effects) are not always easy to make, family doctors are presented with:

1. One or more complexes of functional symptoms in conjunction with one or more stressors (see Patient Profile 2).
2. Organic disease (see Patient Profiles 3 and 5).
3. Organic and functional disease (see Patient Profile 4).

Our task is to differentiate these, primarily by history. By sifting out biological content, and making correlations between symptoms and concerns in an orderly way, we are able to do this with some confidence. A sound understanding of somatization in the context of a biopsychosocial model, is also helpful.[1]

Patient Profile 2

Mrs. P, aged 72, presented with nonspecific abdominal pain. When elucidated as fully as possible, the symptoms lacked the characteristics of any organic pattern. She had symptoms of depression and anxiety that began about the same time as the pain. A significant concern with the dispensation of her will was found to date to the beginning of her symptoms. The rest of the systems enquiry was negative. The *x-y correlation was present:* the tentative diagnosis was functional abdominal pain. Because the possibility of unsuspected organic disease after a complete history and physical exam is small,[3] and because a good physical exam and laboratory screen are almost always sufficient medical investigation of elderly depressed patients,[11] we can reasonably hypothesize at this time that her symptoms of situational depression should respond to situational and problem-solving therapy. If not, she must be reassessed.

Patient Profile 3

Mr. W., age 36, a seaman, presented with chest pain of ten days duration. The pain was not characteristic of any pattern of organic disease. The physical exam revealed normal findings. The patient had no symptoms of reactive depression or anxiety, and denied any concern or changes in his life. The doctor might have simply reassured the patient, except that the *x-y pattern was absent*. Referral was necessary. The internist detected a subtle pericardial friction rub and diagnosed pericarditis.

Patient Profile 4

A middle-aged woman with longstanding Crohn's disease, developed profound fatigue. Her family doctor and specialist both told her repeatedly that her fatigue was secondary to the Crohn's disease and that little could be done to alleviate her symptoms. When she was compelled to seek further advice, the physician enquired about her human concerns. It turned out that her fatigue developed after the murder of a family member *(x-y pattern present)*. The chances of her dealing with her concerns were not helped by being told her symptoms were caused by her preexisting condition.

Patient Profile 5

A 77-year-old man presented with a history of fatigue, weight loss, drop in mood, increased irritability and disturbed sleep for two to four months. Systems enquiry was otherwise negative. This man denied any cause for worry other than his health itself. He considered his life problem-free. Even before the physical exam, the suspicion of organic disease was high because of the absence of an x-y pattern.

The physical exam yielded findings and the pathology report described an enlarged supraclavicular lymph node with histiocytic lymphoma.

Questions

The questions the doctor must ask to form the psychosocial profile can be prefaced with an explanation such as, "Sometimes problems or changes in a person's life affect the way they feel. Do you mind if I ask you some questions about your personal life?" By being sensitive to their social context (i.e. age, sex, family situation, education, religion etc.) and by being aware of the developmental life stage they are experiencing[12] (i.e. postpartum, career-building, retirement, etc.) the questions can be framed tactfully and meaningfully.

Encourage the patient to describe his symptoms in his own terms by using open-ended questions, such as "Can you describe the pain?" General questions can be followed by more specific ones like "How do you sleep?" "Do you have trouble getting to sleep or waking too early?" Similarly, to determine the length of time the patient has had the symptom, the doctor may say, "I realize it's hard to be exact, but can you give me a ballpark figure?" If the response is nonspecific (i.e. "months") ask, "How many months?"

Before asking directly about specific areas in the patient's life, the doctor can sound out the patient generally with, "Can you think of any reason why you are having trouble (i.e. sleeping and eating)?" Even if he does have insight into the cause, going through the list (job, family, friends etc.) is always worthwhile, for example: "Any problems at work or is it OK?" OK is a good word because it implies things are problem-free without being tremendously successful. Things are problem-free or problematic only if the patient perceives them as such.

A patient may have had a concern for a while, but concern about the problem has increased recently. This could coincide with the onset of the symptoms. The shorter, more intense concern can be separated from the continuum by asking, "I gather you've had (for example, marital) concern for several years, but have you had even more lately?" If the answer is "yes", ask "How long is lately?"

You can gain further perspective by asking such questions as: "What do you think is the biggest problem in your life?" "Do you think there is a connection between your symptoms and your concerns?" "How is this affecting your family and work?"

Management of Stress-Related Complaints

If the tentative diagnosis is stress-related then in most cases, my preference is to discuss the possible cause tactfully with the patient. A more traditional approach would differ; Hodgkin in *Towards Earlier Diagnosis*[13] recommends that ". . . because stress can refer to almost any precipitating cause, it is unsatisfactory and should be avoided."

Balint[14] reminds us that a "functional" illness means that the patient has a problem which he unconsciously tried to solve with an illness, and it is therefore protective. He cautions fam-

ily doctors to not think that their immediate task is to uncover the original conflict. Even with that cautionary note, I still feel that working through the correlations of symptoms with significant concerns is a good way to discuss problem(s) and feelings. By responding to the various verbal and nonverbal cues, and by listening actively, a family doctor can lessen the threat that the interview might cause the patient to feel.

When the history is taken in this way, a patient is more likely to accept the diagnosis. Occasionally he might not. He finds it difficult to understand how stress, a psychological phenomenon, can cause his bodily symptoms. Therefore, he feels he is failing to cope or that his pain is imaginary.[14] The doctor can help to reassure him with explanations of the adaptive functions of the body to stress[12] and a statement such as "What you are feeling is a normal reaction to trouble".

The problem solving process depends largely on the patient's responses. Many have the insight to recognize the relationship between their symptoms and concerns, with a fairly quick resolution of the problem. Others benefit from encouragement to list their problems, explore their options and choose a course that feels best, or most reasonable to them. Working on attitudes or acceptance of the situation may be the only possibility.

Additional supportive measures that can be suggested to increase coping ability include: physiotherapy for heat, massage and relaxation exercises, biofeedback, self-hypnosis, a physical fitness program or creative and social activities. Assertiveness training, thought-stopping and quieting techniques can also be helpful. The family doctor is often in the best position to provide the necessary treatment, but depending on his experience or inclination will need to refer to other professionals or social agencies for management of different aspects of patient and/or family therapy.

Symptomatic drug therapy, such as a limited trial of antidepressants or sedatives is beneficial to help some people cope over the short term.[15]

Because we are using symptoms of depression that equally indicate situational *or* major depression (i.e. alterations in sleep, mood, appetite, etc.) those patients who do not respond to situational or problem-solving therapy must be reassessed for the possibility of major depression,[16] or for psychological factors that are maintaining the symptoms.[16, 17] Separating stress, anxiety and depression from psychiatric illness can be difficult. However, the symptoms of stress tend not to be as pervasive and lead to less major biological change.

Conclusion

The presence or absence of an x-y pattern is a helpful guideline for hypothesis formation—but it is not foolproof. The wise doctor is always aware that functional symptoms can precede organic disease e.g., (cancer of the pancreas).[9] Every organic disease has its emotional component, and stress reactions can mask organic symptoms. Fortunately these are exceptions to the rule. A patient can also have a functional complaint for which the doctor is unable to pinpoint an underlying psychosocial problem. This is especially true for hysterical conversion reactions in which the emotional basis is circumvented by being sick.[14] The physician increases his chances of pinpointing the cause without over-investigation (and greater 'dis-ease') by keeping in mind that most functional symptoms are just as characteristic as organic symptoms i.e. frequent or constant, severe, hard to describe, and multiple. Information from family and friends, and judicious use of investigative measures also help.[12]

This approach has not been scientifically tested, but I find the psychosocial profile to be a reliable tool which I use several times daily. It is an attempt at developing a strategy that

—facilitates a working hypothesis of functional and/or organic disease (a diagnostic "wedge").

—decreases the incidence of irrelevant diagnoses which can lead to higher medical costs from inappropriate testing, referral and treatment.

—allows the doctor to understand his patient better in a way that is not unduly time-consuming.

—increases the likelihood that patients will accept a stress-related diagnosis and become active participants in problem-solving and improving their coping skills. ◉

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